The add-ons for programs with an average DDIS score per client greater than 10 points, shall be the difference between the average DDIS score and 10 points, multiplied by $0.459.

(a) The average DDIS score is computed from the sum of the DDIS scores for all clients with a completed DDIS form, divided by the number of clients included in the sum. An average DDIS score resulting in a fraction of a point is rounded up to the next highest point.

(b) A Day Treatment program shall not receive a case mix component if DDIS forms are not completed for a minimum number of clients. The minimum number of clients shall be fifty percent of the average monthly enrollment in the program.

(ii) Staff Training Component - The add-on shall be 0.68 percent of the sum of the fixed amount and the amount of the case mix component.

(iii) Region Component - The add-on shall be for Day Treatment programs in Region I (New York City) and Region II (Nassau, Putnam, Rockland, Suffolk, Westchester) only. In Region I the add-on shall be 12 percent of the sum of the fixed amount, the amount of the case mix component, and the amount

TN 97-08 Approval Date 9/8/98 SEP -8 1998
Supersedes TN 95-27 Effective Date JAN -1 1997 APR -1 1997
JUL -1 1997

of the staff training component. In Region II the add-on shall be four percent of the sum of the fixed amount, the amount of the case mix component, and the amount of the staff training component.

(iv) The regional administrative component for programs located in Region II, with administrative offices located principally in Region I, shall consist of an add-on of $1.90.

(b) For all other allowable day services, there shall be an amount included in the facility's rate to reimburse the facility an amount related to the cost of delivering such services as are reported in accordance with generally accepted accounting principles. The statewide per person annual amounts (calculated using average statewide cost set in 1995 and trended annually) are $9,899 for sheltered workshop and $11,033 for day training. The amount for education and education-related services is calculated using anticipated rate period expenditures and is reconciled annually. Such day services include:

(1) Sheltered workshop services - Work related activities performed in a controlled environment for therapeutic purposes, with or without remuneration and regardless of the likelihood of future paid employment.

(2) Day training services - Activities to promote community integration and foster skills in independent living.

(3) Education and education related services - Training in traditional academic subjects tailored to the special needs of the individual.

(4) Computation of the subsequent period rate

(I) The rate of reimbursement for facilities of under 31 beds shall be determined as follows:

(a) For newly certified facilities as defined in Section (c)(3)(ii)(a) whose base period rate was determined from the base period rate by a trend factor calculated according to Section (c)(3)(vi) and dividing the product by the higher of the actual total reimbursable budget costs, the subsequent period rate shall be determined by multiplying the total reimbursable operating cost portion (not including start-up

allocation or any capital costs) of the reported client days or 99 percent of the total client days as determined by multiplying the certified capacity of the facility by 365 days. If the provider submits a cost report in accordance with §(a)(1)(ii) that reflects a full 12 months of operation, this data shall be used and the rate shall be calculated according to §(c)(3)(ii). Effective with the beginning of the next rate cycle a new base period rate shall be calculated. To determine the capital cost portion of the subsequent period rate, OMRDD may review the base period expense portion relating to capital costs for substantial materials changes, and if said changes conform to the requirements as defined in §(c)(10)(ix), (x) and (xi) make corresponding adjustments in computing the subsequent period rate. To determine the operating cost portion of the subsequent period rate, OMRDD may review the base period expense portion relating to operational costs for substantial material changes, and if said changes conform to the requirements as defined in §(d)(1)(iv) and have received prior approval by OMRDD and Division of the Budget, may make corresponding adjustments in computing the subsequent period rate without the facility being required to file an appeal. Such rates shall be set in accordance with the facility's provider agreement, except as noted in §(c)(4)(ii) and §(c)(4)(iii).

TN 95-27 Approval Date MAY 16 1997
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(b) For facilities other than "newly certified facilities" whose base period was determined from a 12 month cost report, the subsequent period rate shall be determined by multiplying the total reimbursable operating cost portion (not including start-up allocation or any capital costs) of the base period rate by a trend factor calculated according to Section (c)(3)[(v)]<u>(vi)</u> and dividing the product by the higher of the actual reported client days or 99 percent of the total client days as determined by multiplying the certified capacity of the facility by 365 days. To determine the capital cost portion of the subsequent period rate, OMRDD may review the base period portion relating to capital costs for substantial material changes, and if said changes conform to the requirements as defined in §(c)(10)(ix), (x) and (xi) make corresponding adjustments in computing the subsequent period rate. To determine the operating cost portion of the subsequent period rate, OMRDD may review the base period expense portion relating to operational costs for substantial material changes, and if said changes conform to the requirements as defined in §(d)(1)(iv) and have received prior approval by OMRDD and Division of Budget, may make corresponding adjustments in computing the subsequent period rate without the facility being required to file an appeal. Such rates shall be set in accordance with a facility's provider agreement, except as noted in §(c)(4)(ii) and §(c)(4)(iii).

(ii) The Commissioner may make adjustments to rates in the subsequent period based upon error(s) made in computation of the subsequent period rate, <u>changes in payments for real property which have the prior approval of the commissioner and the director of the Division of the Budget</u> or changes in capacity; or based upon final audit findings made in accordance with §(e). If a facility has undergone a change in certified capacity the commissioner may at his discretion:

(a) Request the facility to submit a budget report subject to the provisions of §(a)(1)(i)(b), or,

(b) Request the facility to submit incremental/ decremental cost data, if available, which is associated with the capacity change; and

(c) Utilize submitted incremental/decremental data to make the appropriate upward or downward adjustment in a facility's rate; or

(d) Continue the then existing rate for the remainder of the subject rate period, in those instances, where the commissioner has determined that the facility is operating at a loss for the rate

period in question, and adjusting the rate would further increase the loss, or the facility is operating at a surplus for the rate period in question and adjusting the rate would further increase the surplus.

(iii) Rate adjustments as described in section (c)(4)(ii) will be limited to those adjustments which will result in an increase or decrease in reimbursement of $500 or more.

(iv) For facilities under 31 beds there shall be adjustments in accordance with §(c)(3)(vii)(b) (1), (2) and (3) to the subsequent period rate for day services, such that facilities which have day [treatment] services included in their operating

TN 95-27 Approval Date MAY 16 1997
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OFFICIAL

costs shall be reimbursed in their subsequent period rate for these services by trending the base period day services rate component.

(5) Start-Up costs are those costs which are incurred from the period the provider receives approval pursuant to 14 NYCRR 51 for a facility to become an intermediate care facility, to the date the first client is admitted. However, costs incurred during the period from the first admission to the effective date of the initial provider agreement shall not be considered as start-up costs.

(i) OMRDD may, at the discretion of the Commissioner, reimburse a provider for all or part of the allowable start-up costs incurred in the preparation of the facility during that six month period prior to the date of the first client admission. A provider may apply to the Commissioner for an extension of the 6 month reimbursable start-up period, provided that the provider can demonstrate why such an extension is necessary. However, under no circumstances shall a facility be allowed reimbursement of start-up costs for any period of time exceeding 18 months prior to the date of the first client admission.

(ii) Allowable Start-up costs may include but not be limited to:

(a) Personal service expenses;

(b) Utility expenses;

(c) Taxes;

(d) Insurance expenses;

(e) Employee training expenses;

(f) Housekeeping expenses;

(g) Repair and maintenance expenses; and

(h) Administrative expenses.

(iii) Any costs that are properly identifiable as organization costs or capitalizable as construction costs shall be classified as such and excluded from start-up costs.

(iv) If a provider intends to prepare all portions of its entire facility at the same time, start-up costs for all portions of the facility shall be accumulated in a single deferred account and shall be amortized from the date of the first client admission. However, if a provider intends to prepare only portions of its facility, (e.g., preparation of a floor or wing), start-up costs shall be capitalized and amortized separately. In either case, unless reimbursed as described in (c)(10)(xvi), start-up costs shall be amortized over a period not to exceed 60 months from the date of the first client admission.

TN 91-28 Approval Date Aug 29, 1991
Supersedes TN NEW Effective Date APR 0 1 1991

(6) A facility must also be issued a provider agreement by the Department of Social Services in order to be reimbursed for services delivered.

(7) In order to determine the reimbursable operating costs to be included in the rate calculation for intermediate care facilities of under 31 beds, the following cost category standards (i.e., the maximum amount that will be reimbursed for a specific item or group of items) will be considered. These cost category standards are developed from the available actual cost data obtained from both voluntary and state operated facilities.

(i) Direct Care/Support and Clinical Personal Service cost category standards shall be determined as follows:

(a) For every new rate cycle, OMRDD shall develop values by applying a maximum regional salary amount to a facility's applicable client specific staffing standards. These standards will reflect:

(1) The severity of disabilities of the client population residing at the facility, except that this shall not apply to the support component of the cost category standard.

(2) The number of certified beds in the facility; and

(3) The facility's staffing pattern, except that this shall not apply to the support component of the cost category standard.

(b) Any changes in a facility's staffing pattern that would alter the rate of reimbursement may not be made without prior approval of the Commissioner, and the director of the Division of the Budget.

(c) For any non-state operated facility which elects to participate in the salary enhancement plan as evidenced by adoption of a resolution of its board of directors, effective on the later of October 1, 1987 or the date of adoption of such resolution, the direct care/support reimbursement will be adjusted as follows to reflect the obligation to pay salary levels established by adoption of the resolution referred to above. For non-state operated facilities, base period direct care/support salary costs shall be adjusted as follows:

(1) Regions I & II - $1825 per FTE (deflated to $1606 for 1984/85 base period) not to exceed a maximum of $16,359 per full time equivalent (FTE).

(2) Region III - $1625 per FTE (deflated to $1430 for 1984/85 base period) not to exceed a maximum of $16,359 per full time equivalent (FTE).

(3) The lower of the base period direct care/support salary costs, adjusted as stated above, or the direct care/support salary cost category standard as stated in subsection (f)(1)(ii) trended in accordance with subsection (c)(3)(v), becomes the reimbursable amount for salary enhancement.

(4) In the absence of an election to participate in the salary enhancement plan no adjustment for salary enhancement will be made to the existing rate.

(d) The revised direct care/support personal service cost category standard for Regions I and II will be applied to the state operated facilities' base period direct care/support personal service salary costs and the lower of the two amounts, trended in accordance with subsection (c)(3)(v), will become the allowed direct care/support personal service reimbursement effective October 1, 1987.

(e) To encourage the closure of developmental centers, the commissioner [may] will consider proposals to allow the variable costs associated with the closed facility or facilities to become part of the operating expenses of new or existing state operated community facilities. The commissioner will allow a reasonable incentive plan for the reimbursement of the increased costs referred to above in the state operated community facilities if it is coupled with the closure of a developmental center. An incentive plan would provide for the reimbursement in total of increased costs in the state operated community facilities without adjustments or offsets.

(1) The following reimbursement schedule will be used for proposals approved by the commissioner:

(i) 100 percent reimbursement of the increased cost for at least one full rate period as defined by subsection (c)(2) but less than two full rate periods.

OFFICIAL

(ii) 75 [66] percent reimbursement of the increased cost for the second full rate period following the period defined in subsection (c)(7)(i)(e)(1)(i) above.

(iii) 50 [33] percent reimbursement of the increased cost for the third full rate period.

(iv) 25 percent reimbursement of the increase costs for the fourth full rate period.

(2) Costs to be eligible for this incentive plan will include but not be limited to direct care, support and clinical personal service and fringe benefit amounts for employees whose most recent prior employment was at a closed or scheduled to close developmental center.

(i) In order to have the cost of a former developmental center employee included in the incentive plan, the state operated facility applying for a rate adjustment pursuant to subsection (c)(7)(i)(e) must hire such employee within twelve months of a the official closing date of the developmental center.

(ii) Salaries and fringe benefit amounts paid to eligible employees by the facility cannot exceed the average salary and fringe benefit amount paid to comparable employees currently on that facility's payroll.

(iii) Any claim made under this provision is subject to audit as noted in section (e).

(3) Incentive plan applications from the provider shall be made in writing to the commissioner.

(i) The application shall identify the employees, their job titles, salary levels, date hired and B/DDSO.

(ii) OMRDD may request such additional information as it deems necessary.

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